The Honorable Robert S. Lasnik

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON AT SEATTLE

ANDREA SCHMITT; ELIZABETH MOHUNDRO; and O.L. by and through her parents, J.L. and K.L., each on their own behalf, and on behalf of similarly situated individuals, Plaintiffs, v. KAISER FOUNDATION HEALTH PLAN OF WASHINGTON; KAISER FOUNDATION HEALTH PLAN OF WASHINGTON OPTIONS, INC.; KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST; and KAISER FOUNDATION HEALTH PLAN, INC., Defendants.	CASE NO. 2:17-cv-1611-RSL DECLARATION OF MEDORA A. MARISSEAU

I, Medora Marisseau, hereby declare and state as follows:

1. I am one of the attorneys of record for the Defendants (collectively, "Kaiser") in the above-captioned matter. I make this declaration based on personal knowledge and am otherwise competent to testify to the matters stated herein.

2. Attached hereto as **Exhibit A** is a true and correct copy of excerpts from the deposition of Jessica Hamp, Kaiser's 30(b)(6) witness taken in this case on December 23, 2022, along with a copy of Kaiser's Cochlear Implants/Hearing Devices policy dated June 1, 1997, produced in Defendants' document production (Kaiser 002258-59).

KARR TUTTLE CAMPBELL
701 Fifth Avenue, Suite 3300
Seattle, Washington 98104
Main: (206) 223 1313
Fax: (206) 682 7100

3. Attached hereto as **Exhibit B** is a true and correct copy of the Senate Bill Report on SHB 1870 (relating to the law enacted as RCW 48.43.0128).

4. Pursuant to a public records request, my office received documents from the Office of the Insurance Commissioner regarding its administration of RCW 48.43.0128. Amongst those records was a July 8, 2021 letter, wherein the Office of the Insurance Commissioner ("OIC") sent a notice to Cambia (e.g. Regence BlueShield) that states that the Pediatric Hearing Aid Benefit in its large group plans constituted a discriminatory benefit design within the meaning of RCW 48.43.0128 because the age-limited benefit did not comply with the non-discrimination provisions of Section 1557 of the ACA or the requirements of RCW 48.43.0128. The OIC indicated it would be disapproving all large group plans with a pediatric hearing aid benefit going forward. Attached hereto as **Exhibit C** is a true and correct copy of letter produced by the OIC in response to a public records request submitted by my office.

5. Based on a search of the publicly available Rates and Filing Forms on the OIC's website (https://fortress.wa.gov/oic/onlinefilingsearch/Search.aspx) to search for form filings submitted by Regence after July 8, 2021, a July 12, 2021 replacement form filing submitted by Regence BlueShield that eliminated the pediatric hearing aid benefit entirely and, instead, excluded hearing aids. Attached hereto as **Exhibit D** is a true and correct copy of excerpts from Regence's replacement filing, which is publicly available on the OIC's website.

6. Attached hereto as **Exhibit E** is a true and correct copy of excerpts from the Deposition of Dr. Susan Porter, taken in this case on April 5, 2023.

7. Pursuant to a public records request, my office received documents from the Office of the Insurance Commissioner regarding its administration of RCW 48.43.0128. Amongst those materials was a communication from the OIC to state legislators regarding a 2021 proposed legislative hearing aid mandate. Attached hereto as **Exhibit F** is a true and correct copy of the OIC's communication to legislators, stating that hearing aid coverage would be a "state-mandated benefit" according to federal regulators.

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8. Attached hereto as **Exhibit G** is a true and correct copy of the Department of Health and Human Services' commentary on federal regulations regarding age limits on fertility treatments, 87 FR 27302.

9. Attached hereto as **Exhibit H** is a true and correct copy of excerpts from the deposition of Andrea Schmitt, taken in this case on April 25, 2023.

10. Attached hereto as **Exhibit I** is a true and correct copy of excerpts from the deposition of J.L taken in this case on May 11, 2023.

I declare under penalty of perjury of the laws of the United States that the foregoing is true and correct.

Executed this 20th day of June, 2023, at Seattle, Washington.

s/Medora A. Marisseau
Medora A. Marisseau, WSBA #23114

KARR TUTTLE CAMPBELL
701 Fifth Avenue, Suite 3300
Seattle, Washington 98104
Main: (206) 223 1313
Fax: (206) 682 7100

CERTIFICATE OF SERVICE

I, Luci Brock, affirm and state that I am employed by Karr Tuttle Campbell in King County, in the State of Washington. I am over the age of 18 and not a party to this action. My business address is: 701 Fifth Avenue, Suite 3300, Seattle, Washington 98104. On this day, I caused a true and correct copy of the foregoing document to be filed with the Court and served on the parties listed below in the manner indicated.

Eleanor Hamburger
Richard E. Spoonemore
SIRIANNI YOUTZ SPOONEMORE HAMBURGER
3101 Western Avenue Ste 350
Seattle, WA 98121
206-223-0303
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ehamburger@sylaw.com
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Attorneys for the Plaintiffs

☒ Via U.S. Mail
☐ Via Hand Delivery
☒ Via Electronic Mail
☐ Via Overnight Mail
☒ CM/ECF via court's website

John F. Waldo
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206-849-5009
Email: johnfwaldo@hotmail.com
Attorneys for the Plaintiffs

☒ Via U.S. Mail
☐ Via Hand Delivery
☒ Via Electronic Mail
☐ Via Overnight Mail
☒ CM/ECF via court's website

I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct, to the best of my knowledge.

Executed on this 20th day of June, 2023, at Seattle, Washington.

s/Luci Brock
Luci Brock
Legal Assistant

KARR TUTTLE CAMPBELL
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Seattle, Washington 98104
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Exhibit A

UNITED STATES DISTRICT COURT

WESTERN DISTRICT OF WASHINGTON AT SEATTLE

ANDREA SCHMITT; ELIZABETH MOHONDRO; and O.L. by and through her parents, J.L. and K.L., each on their own behalf and on behalf of all similarly situated individuals,

Plaintiffs,

vs. No. 2:17-cv-01611-RSL

KAISER FOUNDATION HEALTH PLAN OF WASHINGTON; KAISER FOUNDATION HEALTH PLAN OF WASHINGTON OPTIONS, INC; KAISER FOUNDATION HEALTH PLAN OF THE nORTHWEST; and KAISER FOUNDATION HEALTH PLAN, INC.,

Defendants.

ZOOM VIDEO DEPOSITION UPON ORAL EXAMINATION

OF

JESSICA HAMP, 30(b)(6)

9:30 a.m.

December 23, 2022

REPORTED BY: Pat Lessard, CCR #2104

MS. MARISSEAU: Again, object to the form.

When we're talking about hearing aids we're excluding cochlear implants and we're excluding BAHAs, is that right?

A. Correct, yes.

MS. MARISSEAU: Correct. Okay.

Q. (By Ms. Hamburger) You testified earlier in 1995 there was a coverage policy added for cochlear implants.

MS. MARISSEAU: Objection.

Q. (By Ms. Hamburger) Is that right?

A. Not a coverage policy. Clinical criteria.

Q. Clinical criteria. Okay.

When did Kaiser begin including coverage of cochlear implants in its health plans?

A. I'd say at least that date.

Q. When you say that date, 1995 is what you mean?

A. Yes, correct.

Q. And do you know if cochlear implants were covered in individual and small group plans going back to 1995?

A. Yes, I believe so.

Q. So it was in all individual small group and large group plans?

A. Yes, I believe so for cochlear implants.
Q. Okay. And when was the BAHA coverage added?
A. So clinical criteria was developed in the early 2000s, in 2005 or so. That's not to say we didn't cover it before.
And the same with cochlear. We could have well covered it before but maybe developed criteria to apply it more consistently with a clinical criteria policy.
Q. And was this coverage for BAHA added to all plans in 2005?
A. All fully insured plans, I believe so.
Q. Well, let me ask you did the evidence of -- do you call it the evidence of the fully insured plan itself, is that the Evidence of Coverage or Certificate of Coverage?
A. We've used all the terms but these days we call it the Evidence of Coverage.
Q. Evidence of Coverage.
So when did coverage of BAHAs start showing up in the Evidence of Coverage?
A. I want to say 2010 or so. There are times that we cover something and it just may not be described in the Evidence of Coverage. Those documents would get to be a thousand pages long if we

detailed every single benefit.

Q. So I want to draw your attention to Exhibit 22.

(Marked Deposition Exhibit No. 22.)

A. Okay. I've got it pulled open.

Q. (By Ms. Hamburger) Okay. Can you tell me what this is?

A. So this looks to be snippets from our Evidence of Coverage documents of the hearing aid section.

Q. Okay. And were you involved in preparing this document?

A. My team pulled it, but yes, I coordinated some.

Q. Okay. And in 2019 the coverage at issue in this case discusses cochlear implants or bone anchored hearing aids.

Do you see that?

A. Yes.

Q. And do you know if before 2019 bone anchored hearing aids were explicitly included in the Evidence of Coverage?

MS. MARISSEAU: Asked and answered.

A. Yes, I believe so.

Q. (By Ms. Hamburger) All right. I'm going to

show you some -- I think I'm going to have to do it on the sharing the screen. So tell you what, just give me a minute.

I'm going to share the screen. Can you see this?

A. Yes.

Q. Okay. I'm going to identify this as -- the document starts at Kaiser 0001. It's the first document produced in this case. Let me go back.

MS. MARISSEAU: I'm sorry. Can you go to the first page?

MS. HAMBURGER: Yes.

Q. (By Ms. Hamburger) It's from 2014, is that right?

A. Yes, correct.

Q. Okay. And then I'm skipping down to the hearing examinations and hearing aids section.

Do you see that?

A. I do.

Q. Okay. This is on page 24 of the same document.

A. Uh-huh.

Q. And it says "Covered services for cochlear implants."

Do you see that?

KAISER PERMANENTE®

Health Plan Policy
Non-Medicare Policies

Cochlear Implants/Hearing Devices	Policy Number:	NM-017
	Adopted:	06/01/1997
	Last Revised:	05/22/2019
	Last Reviewed:	

PURPOSE:

EXPLANATION:

To ensure consistent administration of the Kaiser Foundation Health Plan of Washington (KFHPWA)/Kaiser Foundation Health Plan of Washington Options, Inc. (KFHPWAO) Evidence of Coverage (EOC) provisions for coverage of cochlear implants and hearing device services.

POLICY:

DESCRIPTION:

Cochlear Implants

A cochlear implant is an electronic device that can enable patients with severe to profound hearing loss to perceive sound. Cochlear implants have two main parts:

1. An internal device that is implanted under the skin behind the ear, and
2. A speech processor that is worn or carried (externally) by the individual.

Osseointegrated Implants (Bone Anchored Hearing Aids - BAHA)

Devices implanted in the skull that replace the function of the middle ear and provide mechanical energy to the cochlea via a mechanical transducer. These are covered as a prosthetic when hearing aids are medically inappropriate or cannot be used due to:

1. Congenital malformations
2. Chronic disease,
3. Severe sensorineural hearing loss, or
4. Surgery

PROCEDURES:

IMPLEMENTING THE BENEFITS ADMINISTRATION POLICY

These procedures provide additional information related to the Benefits Administration Policy, but are separate and distinct from that policy. Benefits Administration Leadership retains discretion in implementing these procedures and can change them at any time, with or without notice.

GUIDELINES:

Cochlear Implants

Cochlear implants, including implant surgery, pre-implant testing, post-implant follow-up, speech therapy, programming and associated supplies (transmitter cable, batteries, etc.) are covered at the medical benefit when Clinical Criteria is met.

Some plans may choose to apply the Devices, Equipment and Supplies benefit for the cochlear implant device and supplies. Check the EOC to confirm the benefit.

Replacement/Repair Cochlear Implants

A cochlear implant includes external components (i.e., a speech processor, a microphone headset and an audio input selector). The life expectancy of a typical processor is between 5-7 years. Before replacement is approved the member must have a durable medical equipment or cochlear implant benefit and the device must no longer be on warrantee or part of a replacement recall. Replacement (L8619) of a cochlear implant and/or its external components is considered for coverage when:

1. The existing device cannot be repaired or when replacement is required because a change in the member's condition makes the present unit non-functional and;
2. Improvement is expected with a replacement unit;
3. A separate assessment is required for recommended accessories and upgrades for a cochlear implant. The member's current condition, the member's capabilities with his/her current cochlear implant, and the member's capabilities of the upgrade or accessory will be considered in determining whether the upgrade or accessory offers clinically significant benefits to the member
4. The evaluation must be conducted by a participating otolaryngologist.

Upgrade Cochlear Implants

Cochlear implant upgrades are only covered when the current device is no longer functioning and the replacement criteria (as stated above) are met.

Bone Anchored Hearing Aids (BAHA)

For most plans, BAHA's, including testing, surgery, fitting, follow-up, speech therapy and programming are covered at the medical benefit when Clinical Criteria is met. BAHA replacement hardware will be covered under the plan's prosthetic devices benefit. Check the DE rider to confirm the benefit.

Evaluation and diagnostic testing are covered even when results reveal the patient is not a candidate. Any tests available at Kaiser Permanente (e.g., tympanometry, computer tomography, etc.) must be provided at Kaiser Permanente.

Associated supplies are covered when device criteria has been met.

EXCLUSIONS:

N/A

APPLICABILITY:

Unless specifically identified as excluded, this policy applies to:
• Kaiser Foundation Health Plan of Washington (KFHPWA)
• Kaiser Foundation Health Plan of Washington Options, Inc. (KFHPWAO)
• Commercial

For Self-Funded plans, refer to the plan document.

SCOPE:

This policy is intended to support consistent benefit application for Kaiser members.

RESPONSIBILITIES:

Benefits Administration is responsible for the interpretation of regulations and guidelines as it relates to policy level coverage determinations. Policies are reviewed on a regular basis to ensure accurate information.

DEFINITIONS:

N/A

REFERENCES:

N/A

Authorized HPSA Authority: Director of Benefits Administration
Designated Content Expert: Benefit Interpretation Coordinator

Exhibit B

SENATE BILL REPORT
SHB 1870

As of March 15, 2019

Title: An act relating to making state law consistent with selected federal consumer protections in the patient protection and affordable care act.

Brief Description: Making state law consistent with selected federal consumer protections in the patient protection and affordable care act.

Sponsors: House Committee on Health Care & Wellness (originally sponsored by Representatives Davis, Cody, Ryu, Jinkins, Dolan, Senn, Bergquist, Peterson, Thai, Valdez, Morgan, Robinson, Goodman, Kilduff, Fey, Pollet, Appleton, Orwall, Mead, Kirby, Kloba, Gregerson, Fitzgibbon, Stanford and Tharinger).

Brief History: Passed House: 3/01/19, 56-38.
Committee Activity: Health & Long Term Care: 3/15/19.

Brief Summary of Bill

- Codifies certain provisions of the federal Patient Protection and Affordable Care Act.

SENATE COMMITTEE ON HEALTH & LONG TERM CARE

Staff: Evan Klein (786-7483)

Background: Patient Protection and Affordable Care Act. The Affordable Care Act (ACA) was passed in 2010, which created the option for states to expand Medicaid, established health insurance exchanges, required most individuals to have health insurance, created penalties for certain large employers who did not offer affordable coverage to their employees, and enacted other requirements relating to medical loss ratios, guaranteed issue, renewability of coverage, and non-discrimination standards.

Essential Health Benefits. The ACA requires non-grandfathered individual and small group market health plans to offer ten essential health benefits (EHB) categories both inside and outside of the Health Benefit Exchange. States establish the essential health benefits using a supplemented benchmark plan.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

Guaranteed Issue. The ACA requires health plans to permit individuals to enroll in the plan regardless of health status, age, gender, or other factors that might predict the use of health services. The ACA also prohibits the extent of coverage offered to an individual from being limited due to the individual's health status.

Prohibition on Unfair Rescissions. The ACA prohibits group and individual health plans from rescinding coverage once an individual is covered under the plan, unless the individual performs an act, practice, or omission that constitutes fraud or makes an intentional misrepresentation of material fact.

Out-Of-Pocket Maximums. The ACA establishes a limit on the out-of-pocket expenses an individual can be required to pay for coverage of EHBs. The ACA sets separate total limits for individual coverage and family coverage, but requires the out-of-pocket limit for individual coverage be applied to each individual covered under a family plan as well.

Lifetime Limits. The ACA prohibits health plans from placing annual or lifetime dollar limits on most benefits received by health plan enrollees.

Explanation of Coverage. The ACA requires insurers and group health plans to provide a summary of benefits and coverage (SBC) to consumers. The SBC must include 12 different content elements; they must be provided to consumers enrolling in a health plan, newly eligible to enroll in a plan, during a special enrollment, whenever coverage changes or is modified, and upon request.

Waiting Periods. The ACA prohibits group health plans and group health insurance issuers from applying any waiting period that exceeds 90 days. A waiting period is defined as the period of time that must pass before coverage becomes effective for an enrollee or dependent who is otherwise eligible to enroll in a plan.

Non-Discrimination. The ACA prohibits a health carrier from making coverage decisions, determining reimbursement amounts, establishing incentive programs, or designing benefits in a way that discriminates against individuals because of their age, disability, or life expectancy. Similarly, health carriers are required to ensure essential health benefits are not subject to denial based on age, life expectancy, disability, degree of medical dependency, or quality of life. Qualified health plans are prohibited from employing marketing practices or benefit designs that have the effect of discouraging enrollment in the plan by individuals with significant health needs.

State law prohibits discrimination in insurance transactions based on sex, marital status, sexual orientation, race, creed, color, national origin, or the presence of any sensory, mental, or physical disability, or the use of a trained dog guide or service animal. Health care service contractors are prohibited from discriminating on the basis of race, religion, national origin, or the presence of any sensory, mental, or physical handicap. Health maintenance organizations are prohibited from discriminating on the basis of any sensory, mental, or physical handicap. This does not prohibit a health care service contractor or health maintenance organization from limiting or denying coverage when a person does not meet essential eligibility requirements because of a medical condition.

Summary of Bill: Guaranteed Issue and Eligibility. A health carrier is prohibited from rejecting an applicant based on a pre-existing condition. Similarly, a health carrier may not deny, exclude, or otherwise limit coverage for an individual's pre-existing condition, including pre-existing condition exclusions or waiting periods. Provisions relating to pre-existing condition exclusions and waiting periods and the standard health questionnaire are eliminated or repealed.

A health carrier may not establish eligibility rules based on:

- health status;
- medical condition;
- claims experience;
- receipt of health care;
- medical history;
- genetic information;
- evidence of insurability;
- disability; or
- any other health status-related factor determined appropriate by the insurance commissioner (commissioner).

Open Enrollment Periods. The commissioner's requirement to establish open enrollment periods is expanded to include all persons, instead of only persons under the age of nineteen. The commissioner may levy fines against a carrier that refuses to sell guaranteed issue policies to any person, instead of only persons under the age of nineteen.

Rescissions. A health plan or health carrier may not rescind coverage for an enrollee once the enrollee is covered under the plan, except in situations involving fraud or material misrepresentation.

Essential Health Benefits. The ten essential health benefit categories are defined to include:

- ambulatory patient services;
- emergency services;
- hospitalization;
- maternity and newborn care;
- mental health and substance use disorder treatment, including behavioral health treatment;
- prescription drugs;
- rehabilitative and habilitative services and devices;
- laboratory services;
- preventive and wellness services and chronic disease management; and
- pediatric services, including oral and vision care.

References to federal law are eliminated in provisions relating to selecting and supplementing of the state benchmark plan.

Out-of-Pocket Maximums. For plan years beginning in 2020, the cost-sharing incurred under a health plan for the essential health benefits may not exceed the amount required under federal law for the calendar year. If there are no cost-sharing requirements under federal law, the cost sharing may not exceed $8,200 for self-only coverage and $16,400 for family

coverage, increased by the premium adjustment percentage for the calendar year. An enrollee's cost-sharing may not exceed the self-only limit regardless of whether he or she is enrolled in self-only or family coverage.

The premium adjustment percentage for the calendar year is the percentage, if any, by which the average per capita premium for health insurance in Washington for the previous year exceeds the average per capita premium for 2020 as determined by the commissioner.

Lifetime Limits. A health carrier may not impose annual or lifetime limits on an essential health benefit, other than those permitted as reference-based limitations under rules adopted by the commissioner.

Explanation of Coverage. A health carrier must provide a summary of benefits and coverage explanation (SBCE), either in paper or electronically, to:

- an applicant at the time of application;
- an enrollee prior to the time of enrollment or re-enrollment; and
- a policy holder or certificate holder at the time of issuance.

The commissioner must develop standards for health carriers to use when providing a SBCE to applicants, enrollees, and policyholders. The standards require the SBCE be presented in a uniform format of four pages or less in at least 12-point font, is culturally and linguistically appropriate, and uses terms understandable by the average enrollee, and includes:

- uniform definitions that allow consumers to compare coverage and understand the terms of coverage;
- a description of the coverage, reductions and exceptions on coverage, cost-sharing provisions, and renewability and continuation of coverage provisions;
- a coverage facts label that includes examples to illustrate common benefits scenarios, including pregnancy and serious or chronic medical conditions and related cost sharing;
- a statement of whether the plan provides minimum essential coverage under federal law and ensures the plan share of total allowed costs is no less than 60 percent of the costs;
- a statement that the outline is a summary and the coverage document itself should be consulted to determine the governing contractual provisions; and
- a contact number for the consumer to call with additional questions and a website where a copy of the actual individual coverage policy or group certificate of coverage may be reviewed and obtained.

The commissioner must use the current federal SBCE standards when developing the state standards. The commissioner must periodically review and update the standards. If a health carrier makes any material modification in any of the terms of the plan that is not reflected in the most recent SBCE, it must provide notice of the modification no less than 60 days prior to the date the modification becomes effective.

A health carrier that fails to provide the required information is subject to a fine of no more than $1,000 for each failure. A failure for each enrollee constitutes a separate offense.

The commissioner must develop standards for definitions of terms to be used on health insurance coverage, including insurance-related terms and medical terms.

Waiting Periods for Group Coverage. A group health plan and a health carrier offering group coverage may not apply any waiting period that exceeds 90 days.

Non-Discrimination. A health carrier may not make coverage decisions, determine reimbursement amounts, establish incentive programs, or design benefits in a way that discriminates against individuals because of their age, disability, or life expectancy. Health carriers must ensure that essential health benefits are not subject to denial based on age, life expectancy, disability, degree of medical dependency, or quality of life. Qualified health plans may not employ marketing practices or benefit designs that have the effect of discouraging enrollment in the plan by individuals with significant health needs.

Rulemaking. Unless preempted by federal law, the commissioner must adopt any rules necessary to implement the provisions relating to guaranteed issue and eligibility, open enrollment periods, limitations on rescissions, essential health benefits, out-of-pocket maximums, prohibiting annual or lifetime limits, uniform explanation of coverage requirements, maximum waiting periods for group coverage, and discrimination prohibitions. The rules must be consistent with federal rules and guidance in effect on January 1, 2017, implementing the ACA.

Appropriation: None.

Fiscal Note: Available.

Creates Committee/Commission/Task Force that includes Legislative members: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony: PRO: When the ACA past in 2010, it took away fear that people would be denied health care coverage, or dropped from coverage. This bill seeks to ensure people of Washington will be protected, regardless of what happens at the federal level. This bill protects denials of coverage for people with preexisting conditions and codifies the essential health benefits. These provisions directly impact patients. Lifetime caps significantly affect families with chronic diseases. People with preexisting conditions need insurance that covers them, to ensure they can stay employed. Every time the federal government threatens to remove these protections, it terrifies families and patients. Without these protections prohibiting coverage discrimination, people with preexisting conditions might get coverage, but might not have coverage that pays for their conditions.

Persons Testifying: PRO: Representative Lauren Davis, Prime Sponsor; Stephanie Simpson, Bleeding Disorder Foundation of Washington; Alexa Silver, Northwest Health Law Advocates.

Persons Signed In To Testify But Not Testifying: No one.

Exhibit C

MIKE KREIDLER
STATE INSURANCE COMMISSIONER

STATE OF WASHINGTON

Phone: 360-725-7000
www.insurance.wa.gov

OFFICE OF
INSURANCE COMMISSIONER

July 08, 2021

Cambia Health Solutions
1800 9th AVE.
Seattle, WA 98101

RE: Age-Limited Hearing Aid Benefits in Cambia Health Solutions' Large Group Contracts

Cambia Health Solutions health plan filers,

The OIC has determined that Cambia Health Solutions' (Cambia) age-limited hearing aid benefit does not comply with the non-discrimination provisions of Section 1557 of the Affordable Care Act (ACA) and the requirements of RCW 48.43.0128 and WAC 284-43-5940.

Effective immediately, the OIC is disapproving all plan year 2021 large group contracts that include an embedded pediatric hearing aid benefit.

To minimize consumer disruption, Cambia may continue to administer currently in-force health plan(s) through the end of current plan year. The health plan cannot be sold to any new groups and no renewals are allowed.

If you have any questions, please contact Kim Tocco, Health Forms Manager.

Thank you for your cooperation.

Sincerely,

Molly Nollette,
Deputy Commissioner of Rates, Forms, and Provider Networks

CC: Kim Tocco, Health Forms Compliance Manager
Addie Hawkins, Health Forms Compliance Analyst
Zach Snyder, Director of Government Affairs

Exhibit D

State: *Washington* ***Filing Company:*** *Regence BlueShield*
TOI/Sub-TOI: *H16G Group Health - Major Medical/H16G.002C Large Group Only - Other*
Product Name: *Large Group Std. Master Regence Innova*
Project Name/Number: *082021 Regence Innova 51+/WW0821BINNL*

Filing at a Glance

Company:	Regence BlueShield
Product Name:	Large Group Std. Master Regence Innova
State:	Washington
TOI:	H16G Group Health - Major Medical
Sub-TOI:	H16G.002C Large Group Only - Other
Filing Type:	Form
Date Submitted:	07/12/2021
SERFF Tr Num:	RGWA-132904640
SERFF Status:	Closed-Filed
State Tr Num:	412948
State Status:	Filed
Co Tr Num:	WW0821BINNL
Effective Date Requested:	08/01/2021
Author(s):	Sue Kanitz, Jason Wadsworth, Kathy Ward, Victoria Bodanza, Marc Guzman, Josh Lucas, Andrea Stockwell-Johnson, Tasha Williams-Davis, Daniel Sobel, Christa Fitzpatrick, Lanikka Batts, Nikki Morrison, Sharna Baldwin
Reviewer(s):	Addie Hawkins (primary)
Disposition Date:	09/21/2021
Disposition Status:	Filed
Effective Date:	08/01/2021
Destruction Date:	

State Filing Description:

State:	*Washington*	***Filing Company:***	*Regence BlueShield*
TOI/Sub-TOI:	*H16G Group Health - Major Medical/H16G.002C Large Group Only - Other*		
Product Name:	*Large Group Std. Master Regence Innova*		
Project Name/Number:	*082021 Regence Innova 51+/WW0821BINNL*		

General Information

Project Name: 082021 Regence Innova 51+
Project Number: WW0821BINNL
Requested Filing Mode: File & Use
Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Employer
Filing Status Changed: 09/21/2021
State Status Changed: 09/21/2021
Created By: Andrea Stockwell-Johnson
Corresponding Filing Tracking Number:

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Large
Overall Rate Impact:

Deemer Date:
Submitted By: Andrea Stockwell-Johnson

PPACA: Not PPACA-Related

PPACA Notes: null

Include Exchange Intentions: No

Filing Description:

Attached for your review are the large group standard master documents for Regence Innova to ensure compliance with state and federal law. These master documents are actively marketed to group size 51+ segment. These masters will be effective on or after August 1, 2021 for new groups or on the date on which groups renew with us, whichever is later.

A variability document and redlines of the contract and booklet are included in this filing to assist in your review. There is no separate rate filing at this time as rates are filed as negotiated.

Company and Contact

Filing Contact Information

Josh Lucas, Benefit Contract Compliance Analyst
1800 9th Avenue, MS S455, PO Box 21267
Seattle, WA 98111-3267

Josh.Lucas@cambiahealth.com
206-332-4961 [Phone]

Filing Company Information

Regence BlueShield
1800 9th Avenue, MS S455
PO Box 21267
Seattle, WA 98111-3267
(800) 422-7076 ext. [Phone]

CoCode: 53902
Group Code:
Group Name:
FEIN Number: 91-0282080

State of Domicile: Washington
Company Type:
State ID Number:

2021 BOOKLET FOR:

[GROUP NAME]

Regence Innova®

[Additional Title]

Group Number: [Group Number]

Regence BlueShield Medical Benefits

Regence

Payment: After Deductible, You pay **[**10 / 20 / 30**]**% of the Allowed Amount.	**Payment:** After Deductible, You pay **[**30 / 40 / 50**]**% of the Allowed Amount.	**Payment:** After Deductible, You pay **[**30 / 40 / 50**]**% of the Allowed Amount and You pay any balance of billed charges.
Limit: 30 visits per Member per Calendar Year		

Palliative care is covered when a Provider has assessed that a Member is in need of palliative services for a serious Illness (including remission support), life-limiting Injury or end-of-life care. "Palliative care" means specialized services received from a Provider in a home setting for counseling and home health aide services for activities of daily living.

Palliative care visits apply to the Maximum Benefit limit for these services, including palliative care visits that are applied toward any Deductible. All other Covered Services for a Member receiving palliative care remain covered the same as any other Illness or Injury.

~~**PEDIATRIC HEARING AIDS AND EVALUATIONS**~~

~~**Category: 1**~~	~~**Category: 2**~~	~~**Category: 3**~~
~~**Provider: Preferred**~~	~~**Provider: Participating**~~	~~**Provider: Nonparticipating**~~
~~**Payment:** After Deductible, You pay **[**10 / 20 / 30**]**% of the Allowed Amount.~~	~~**Payment:** After Deductible, You pay **[**30 / 40 / 50**]**% of the Allowed Amount.~~	~~**Payment:** After Deductible, You pay **[**30 / 40 / 50**]**% of the Allowed Amount and You pay any balance of billed charges.~~
~~**[Limit:** $4,000 per Member every three Calendar Years**]**~~		
~~**[Limit:** two hearing aids per Member every **{**two – three**}** Calendar Year**{**s**}]**~~		

~~Hearing aids and any associated evaluations are covered for Members through age 18 when necessary for treatment of hearing loss. Covered Services include the following:~~

- ~~hearing aids (including evaluations);~~
- ~~bone conduction sound processors (including examinations and fittings);~~
- ~~ear molds and replacement ear molds; and~~
- ~~hearing aid checks and testing.~~

~~"Hearing aid" means any nondisposable, wearable instrument designed to aid or compensate for impaired human hearing and any necessary part or ear mold for the instrument.~~

~~**[**Hearing aids apply to the Maximum Benefit limit for these services, including Hearing aids that are applied toward any Deductible. **]**Cochlear implants are covered the same as any other Illness or Injury.~~

~~Covered Services do not include:~~

- ~~routine hearing examinations;~~
- ~~hearing assistive technology systems; or~~
- ~~the cost of batteries or cords.~~

PROSTHETIC DEVICES

Category: 1	**Category: 2**	**Category: 3**
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay **[**10 / 20 / 30**]**% of the Allowed Amount.	**Payment:** After Deductible, You pay **[**30 / 40 / 50**]**% of the Allowed Amount.	**Payment:** After Deductible, You pay **[**30 / 40 / 50**]**% of the Allowed Amount and You pay any balance of billed charges.

Government Programs
Except as required by state law (such as cases of medical emergency or coverage provided by Medicaid) or for facilities that contract with Us, benefits that are covered (or would be covered in the absence of this plan) by any federal, state or government program are not covered.

Additionally, except as listed below, government facilities or government facilities outside the service area are not covered:

- facilities contracting with the local Blue Cross and/or Blue Shield plan; or
- as required by law for emergency services.

Hearing Aids and Other Devices
Except for cochlear implants ~~or as provided in the Pediatric Hearing Aids and Evaluations benefit~~, hearing aids (externally worn or surgically implanted) or other hearing devices are not covered.

Hypnotherapy and Hypnosis Services
Hypnotherapy and hypnosis services and associated expenses are not covered, including, but not limited to:

- treatment of painful physical conditions;
- Mental Health Conditions;
- Substance Use Disorders; or
- for anesthesia purposes.

Illegal Services, Substances and Supplies
Services, substances and supplies that are illegal as defined by state or federal law.

Individualized Education Program (IEP)
Services or supplies, including, but not limited to, supplementary aids and supports as provided in an IEP developed and adopted pursuant to the Individuals with Disabilities Education Act.

Infertility
Except **[**as provided in the Infertility Treatment benefit or**]** to the extent Covered Services are required to diagnose such condition, treatment of infertility is not covered, including, but not limited to:

- surgery;
- fertility drugs; and
- other medications associated with fertility treatment.

Investigational Services
Except as provided in the Approved Clinical Trials benefit, Investigational services are not covered, including, but not limited to:

- services, supplies and accommodations provided in connection with Investigational treatments or procedures (Health Interventions); and
- any services or supplies provided by an Investigational protocol.

Refer to the expanded definition of Experimental/Investigational in the Definitions Section.

Motor Vehicle No-Fault Coverage
Expenses for services and supplies that have been covered or have been accepted for coverage under any automobile medical personal injury protection ("PIP") no-fault coverage. If Your expenses for services and supplies have been covered or have been accepted for coverage by an automobile medical personal injury protection ("PIP") carrier, We will provide benefits according to the Contract once Your claims are no longer covered by that carrier.

Non-Direct Patient Care
Except as provided in the Virtual Care benefit, non-direct patient care services are not covered, including, but not limited to:

For more information call Us at 1 (888) 367-2112

regence.com

[*This plan arranged by:*

{Producer Information**}]**

Regence

Exhibit E

UNITED STATES DISTRICT COURT

WESTERN DISTRICT OF WASHINGTON AT SEATTLE

ANDREA SCHMITT; ELIZABETH MOHONDRO; and O.L. by and through her parents, J.L. and K.L., each on their own behalf and on behalf of all similarly situated individuals,

Plaintiffs,

vs. No. 2:17-cv-01611-RSL

KAISER FOUNDATION HEALTH PLAN OF WASHINGTON; KAISER FOUNDATION HEALTH PLAN OF WASHINGTON OPTIONS, INC; KAISER FOUNDATION HEALTH PLAN OF THE nORTHWEST; and KAISER FOUNDATION HEALTH PLAN, INC.,

Defendants.

ZOOM DEPOSITION UPON ORAL EXAMINATION

OF

SUSAN PORTER

9:30 a.m.

April 5, 2023

REPORTED BY: Pat Lessard, CCR #2104

Q. Yes. But again, I'm not saying -- certainly there might be exceptions. I'm not saying 100 percent moderate to profound that use hearing aids.

But the vast majority of people for whom you have assisted getting hearing aids, those folks have moderate to profound -- moderate to severe hearing loss, is that right?

MS. MARISSEAU: Object to the form, asked and answered.

A. I don't believe I can answer that as being the truth. I've seen a variety of different hearing losses over the years and different patients choosing to be fit and get benefit.

Q. (By Ms. Hamburger) Have you ever looked at the utilization data on who uses hearing aids in the United States?

A. Yes, I am familiar with some of that data.

Q. Okay. And isn't it true in that data that the vast majority of people who are using hearing aids are people with moderate to severe hearing loss?

MS. MARISSEAU: Object to form. Vague.

A. I don't recall the percentages but I believe the percentage of patients does go up as the severity of loss gets a little bit worse.

But then there's also patients that fall

into the category, as hearing loss gets more severe to profound, of using Cochlear implants. Or there's other types of devices like bone-anchored devices and things like that that can fall into those populations as well.

Q. (By Ms. Hamburger) Well, would you say that the majority of people who use hearing aids have moderate to severe hearing loss?

MS. MARISSEAU: Asked and answered, Counsel.

A. I don't believe I can state that.

Q. (By Ms. Hamburger) How often do you review the literature related to the use of hearing aids?

A. Infrequently.

Q. When you do clinical work for Kaiser do you provide diagnostic hearing examinations?

A. I do. That's primarily what I've done when I have recently gone in and provided care.

Q. Okay. And what happens in a diagnostic hearing examination?

A. There's a variety of tests that are performed as part of a standard diagnostic evaluation. Within Kaiser we also have a standard of which tests we perform routinely for patients that come in for hearing tests.

Q. Okay. Can you describe what those tests

Exhibit F

MIKE KREIDLER
STATE INSURANCE COMMISSIONER

STATE OF WASHINGTON
OFFICE OF
INSURANCE COMMISSIONER

Phone: 360-725-7000
www.insurance.wa.gov

April 19, 2021

Senator Christine Rolfes
303 John A. Cherberg Building
Post Office Box 40423
Olympia, Washington 98504

Senator Karen Keiser
219 John A. Cherberg Building
Post Office Box 40433
Olympia, WA 98504

Senator June Robinson
223 John A. Cherberg Building
Post Office Box 40438
Olympia, WA 98504

RE: Hearing instrument coverage for children (Section 140(3) Engrossed Substitute Senate Bill 5092)

Senator Rolfes, Robinson and Keiser,

I'm writing to you regarding a budget proviso in the House budget related to House Bill (HB) 1047 – hearing instrument coverage for children. Last fall, Representatives Wicks and Orwall approached my office with their intent to introduce legislation that would require private health plans to cover hearing instruments for children and adolescents. We reviewed the provisions of the Affordable Care Act (ACA) that apply to situations in which a state requires coverage of services in addition to the Essential Health Benefits (EHB) benchmark plan. Washington State's EHB includes coverage of cochlear implants, but not other types of hearing instruments.

The ACA requires that states defray the cost of mandated benefits in individual health plans that are in addition to the EHB. As a result of my office's discussions with Representatives Wicks and Orwall, my office met with staff from the federal Center for Medicare and Medicaid Services (CMS). Staff from CMS confirmed our analysis that providing hearing aid coverage would create a mandated benefit and require the state to defray the costs of coverage for these benefits in the individual market. In addition, the ACA nondiscrimination provisions likely preclude limiting the benefit to children and adolescents.

My office conducted an informal inquiry with health carriers in Washington State regarding the potential cost of the services described in HB 1047. Unfortunately, the responses received from the health carriers indicated significant variation in costs and we were unable to provide the House with definitive cost information.

As an alternative to moving HB 1047, section 140(3) of the House budget directs the Office of the Insurance Commissioner (OIC) to contract with consultants to obtain projected utilization and cost data from Washington State carriers in order to provide a more definitive estimate of the cost of the benefits described in HB 1047, and to develop recommendations as to how state payments to defray the cost of the benefit could be implemented.

Mailing Address: PO Box 40255 Olympia, WA 98504-0255
Street Address: 5000 Capitol Blvd Tumwater WA 98501

With the exception of one mandate bill that passed several years ago with virtually no cost, the legislature has not enacted any new mandate bills since enactment of the ACA, due to the unknowns and potential costs. The OIC has not had the opportunity to develop an approach to determine the costs of new mandates or to determine how the state would defray the cost of the mandate if enacted; this proviso would create that opportunity.

I fully understand the importance of hearing aids in a child's ability to learn and the need for better information on the potential cost of these services. This proviso and the information it would make available would be of benefit to the Legislature and others

Sincerely,

Mike Kreidler,
Insurance Commissioner

Sent electronically

Exhibit G

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Parts 144, 147, 153, 155, 156, and 158

[CMS–9911–F]

RIN 0938–AU65

Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: This final rule includes payment parameters and provisions related to the risk adjustment and risk adjustment data validation programs, as well as 2023 user fee rates for issuers offering qualified health plans (QHPs) through Federally-facilitated Exchanges (FFEs) and State-based Exchanges on the Federal platform (SBE–FPs). This final rule also includes requirements related to guaranteed availability; the offering of QHP standardized plan options through Exchanges on the Federal platform; requirements for agents, brokers, and web-brokers; verification standards related to employer sponsored coverage; Exchange eligibility determinations during a benefit year; special enrollment period verification; cost-sharing requirements; Essential Health Benefits (EHBs); Actuarial Value (AV); QHP issuer quality improvement strategies; accounting for quality improvement activity (QIA) expenses and provider incentives for medical loss ratio (MLR) reporting and rebate calculation purposes; and re-enrollment. This final rule also responds to comments on how the Department of Health and Human Services (HHS) can advance health equity through QHP certification standards and otherwise in the individual and group health insurance markets, and how HHS might address plan choice overload in the Exchanges.

DATES: These regulations are effective July 1, 2022.

FOR FURTHER INFORMATION CONTACT:

Cam Moultrie Clemmons, (206) 615–2338, or Anthony Galace, (301) 492–4400, for matters related to past-due premiums.

Allison Yadsko, (410) 786–1740, John Barfield, (301) 492–4433, Jacqueline Wilson, (301) 492–4286, or Leanne Klock, (410) 786–1045, for matters related to risk adjustment or risk adjustment data validation.

Aaron Franz, (410) 786–8027, or John Barfield, (301) 492–4433, for matters related to Federally-facilitated Exchange and State-based Exchange on the Federal platform user fees.

Nora Simmons, (410) 786–1981, for matters related to advance payment of the premium tax credit proration.

Aaron Franz, (410) 786–8027, or Hi'ilei Haru, (301) 492–4363, for matters related to cost-sharing reduction reconciliation.

Josh Van Drei, (410) 786–1659, for matters related to actuarial value.

Becca Bucchieri, (301) 492–4341, Agata Pelka, (301) 492–4400, or Leigha Basini, (301) 492–4380, for matters related to nondiscrimination based on sexual orientation and gender identity, essential health benefit benchmark plans, and defrayal of State-required benefits.

Marisa Beatley, (301) 492–4307, for matters related to employer sponsored coverage verification.

Susan Kalmus, (301) 492–4275, for matters related to agent, broker, and web-broker guidelines.

Dena Nelson, (240) 401–3535, or Carly Rhyne, (301) 492–4188, for matters related to eligibility standards.

Katherine Bentley, (301) 492–5209, or Ariel Kennedy, (301) 492–4306, for matters related to special enrollment period verification.

Christina Whitefield, (301) 492–4172, for matters related to the medical loss ratio program.

Nidhi Singh Shah, (301) 492–5110, for matters related to quality improvement strategy standards for Exchanges.

Dan Brown, (301) 492–5146 for matters related to downstream and delegated entities.

Nikolas Berkobien, (301) 492–4400, or Leigha Basini, (301) 492–4380 for matters related to standardized plan options.

Erika Melman, (301) 492–4348, Deborah Hunter, (443) 386–3651, Whitney Allen, (667) 290–8748, or Emily Martin, (301) 492–4423, for matters related to network adequacy and essential community providers.

Linus Bicker, (803) 931–6185, for matters related to State Exchange improper payment measurement.

Phuong Van, (202) 570–5594, for matters related to advancing health equity through qualified health plans.

Angelica Torres-Reid, (410) 786–1721, and Robert Yates, (301) 492–5151, for matters related to State Exchange general program integrity and oversight requirements.

Zarah Ghiasuddin, (301) 492–4308, for matters related to re-enrollment in the Exchanges.

SUPPLEMENTARY INFORMATION:

Table of Contents

policy reflected in this example does not apply to benefits that are not covered by a plan as EHB. For example, pursuant to § 155.170, a health benefit an issuer covers under a plan pursuant to a State mandate adopted on or after January 1, 2012, other than for purposes of compliance with Federal requirements, is not considered EHB and would not be subject to the policy reflected in this example.

2. Autism Spectrum Disorder (ASD) Coverage Limitations Based on Age

a. *Background:* According to the American Psychiatric Association, ''[p]eople with ASD may have communication deficits, such as responding inappropriately in conversations, misreading nonverbal interactions, or having difficulty building friendships appropriate to their age. In addition, people with ASD may be overly dependent on routines, highly sensitive to changes in their environment, or intensely focused on inappropriate items.'' [284]

b. *Circumstance:* We noted that some States have mandated coverage for the diagnosis and treatment for of ASD up to a certain age. For example, a State has required coverage for enrollees up to age 18 with certain cost-sharing conditions. Similarly, some States' EHB-benchmark plans that cover applied behavior analysis (ABA therapy) include age limits.

c. *Rationale:* The CDC recognizes the American Psychiatric Association's fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM–5) as standardized criteria to help diagnose ASD.[285] Under the DSM–5 criteria, individuals with ASD must show symptoms from early childhood, but may not be fully recognized until later in life.[286] We noted that screening for ASD is usually done at a young age although an individual may not be diagnosed until later in life. The CDC estimates that 2.21 percent of adults in the U.S. have ASD.[287]

d. *Conclusion:* Age limits are presumptively discriminatory under § 156.125 when applied to services that are covered as EHB and there is no clinical basis for the age limitation. A plan subject to § 156.125 that covers diagnoses and treatment of ASD as an EHB, but limits such coverage in its plan benefit design based on age is presumptively discriminatory under § 156.125 unless the limitation is clinically based. This example does not apply to benefits that are not EHB. For example, pursuant to § 155.170, a benefit required by State action taking place on or after January 1, 2012, other than for purposes of compliance with federal requirements, is not considered EHB, and this example would not apply.

3. Age Limits for Infertility Treatment Coverage When Treatment Is Clinically Effective for the Age Group

a. *Background:* The National Center for Health Statistics reported that 8.8 percent of couples in the U.S. have experienced infertility issues while 9.5 percent have received infertility services (for example, medical assistance, counseling, testing for the woman and man, ovulation drugs, fallopian tube surgery, artificial insemination, assisted reproductive technology, and miscarriage preventive services).[288]

b. *Circumstance:* We noted that some States have defined ''infertility'' in State law, which impacts insurance companies, hospitals, medical service corporations, and health care centers providing coverage for medically necessary expenses of the diagnosis and treatment of infertility. For example, a State restricted coverage for treatment of infertility to individuals who are ''presumably healthy,'' thus excluding from coverage of treatment for infertility those who are not presumably healthy.

c. *Rationale:* We noted that an individual's age is an important factor for reproductive health and development. Fertility, especially in women, declines with age, which makes natural conception more unlikely as women get older.[289] However, we also noted that the mean age for individuals experiencing their first childbirth has increased in recent years.[290] We also understand that not all individuals would be eligible for infertility treatment if they are not at the stage of development for reproduction or have certain medical conditions. Younger individuals, for example, who are not at the stage of reproductive development would reasonably not require treatment for infertility. Older adults as well would not need treatment for infertility, for example women who have reached post-menopause.

d. *Conclusion:* Age limits are presumptively discriminatory under § 156.125 when applied to EHB services and there is no clinical basis for the age limitation. A plan subject to § 156.125 that covers treatment of infertility as an EHB but limits such coverage in its plan benefit design based on age is presumptively discriminatory under § 156.125 unless the limitation is clinically based. An issuer could rebut the presumption that the plan's age limit on the coverage for treatment of infertility is discriminatory by demonstrating clinical evidence that infertility treatments have low efficacy for the excluded age groups and/or are not clinically indicated for the excluded age groups. This example does not apply to benefits that are not EHB. For example, pursuant to § 155.170, a benefit required by State action taking place on or after January 1, 2012, other than for purposes of compliance with federal requirements, is not considered EHB and this example would not apply.[291]

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[284] *Autism Spectrum Disorder.* (2013). American Psychiatric Association. *https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA_DSM-5-Autism-Spectrum-Disorder.pdf.*

[285] *Autism Spectrum Disorder (ASD).* (2020, June 29). CDC. *https://www.cdc.gov/ncbddd/autism/hcp-dsm.html.*

[286] American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 5th ed. Arlington, VA: American Psychiatric Association; 2013.

[287] *Key Findings: CDC Releases First Estimates of the Number of Adults Living with Autism Spectrum Disorder in the United States.* (2020, April 27). CDC. *https://www.cdc.gov/ncbddd/autism/features/adults-living-with-autism-spectrum-disorder.html.*

[288] Infertility Statistics. (2021, December 20). CDC. *https://www.cdc.gov/nchs/fastats/infertility.htm.*

[289] *Having a Baby After Age 35: How Aging Affects Fertility and Pregnancy.* (2020). American College of Obstetricians and Gynecologists. *https://www.acog.org/womens-health/faqs/having-a-baby-after-age-35-how-aging-affects-fertility-and-pregnancy.*

[290] Mean Age of Mothers is on the Rise: United States, 2000–2014. (2016, January 14). CDC. *https://www.cdc.gov/nchs/products/databriefs/db232.htm.*

[291] *Key Statistics from the National Survey of Family Growth.* (2017, June 20). CDC. *https://www.cdc.gov/nchs/nsfg/key_statistics/i.htm.*

[292] Routine Foot Care. *Medicare Benefit Policy Manual* (pp. 265). CMS. *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf.*

Exhibit H

UNITED STATES DISTRICT COURT

WESTERN DISTRICT OF WASHINGTON

AT SEATTLE

ANDREA SCHMITT; ELIZABETH MOHUNDRO; and O.L., by and through her parents, J.L. and K.L., each on their own behalf, and on behalf of all similarly situated individuals, Plaintiffs, v. KAISER FOUNDATION HEALTH PLAN OF WASHINGTON; KAISER FOUNDATION HEALTH PLAN OF WASHINGTON OPTIONS, INC.; KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST; and KAISER FOUNDATION HEALTH PLAN, INC., Defendants.	CASE NO. 2:17-cv-1611-RSL

DEPOSITION UPON ORAL EXAMINATION

VIA ZOOM VIDEOCONFERENCING

OF

ANDREA SCHMITT

DATE: Tuesday, April 25, 10:16 A.M.

REPORTED BY: Annamarie C. Spangrud, CCR

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I N D E X O F E X A M I N A T I O N

I N D E X OF E X H I B I T S

I N D E X OF E X H I B I T S

[Continued]

EXHIBIT	DESCRIPTION	MARKED	IDENTIFIED
EX. 5	CONFIDENTIAL AND SUBJECT TO A PROTECTIVE ORDER Invoices from Complete Hearing & Balance (15 pages)	45	45
EX. 6	Fourth Amended Complaint (33 pages)	105	104

A. I mean, it appears to say that here.
Q. All right.
MS. HAMBURGER: Counsel --
Q. [By Ms. Marisseau] Do you have any --
MS. HAMBURGER: I'm sorry. Is there any indication of the year that this plan was in effect?
MS. MARISSEAU: I believe there is, but we can answer your questions after we take a break.
Q. [By Ms. Marisseau] Have you done anything to -- well, did you file any claims while you were covered under Jeff's King County Group Health policy for anything as far as you recall?
A. I don't -- I don't recall filing any claims. I certainly received care and, you know, got coverage for things that were -- you know, that I was getting care for. I didn't -- I don't believe I filed any claims that needed to be separately filed.
Q. Okay. Can you tell me, if you have an understanding, of what "network" or "out-of-network" means?
A. I mean, I would -- I would have to -- I would have to surmise that, you know, within the Kaiser system that "network" probably refers to, you know, providers who are specifically employed by or contracted by Kaiser.

Q. Okay.

MS. MARISSEAU: Let's go to Page 30, please. Yes, let's blow it up because its really small. There we go. That's better.

Q. [By Ms. Marisseau] Okay. Are you able to see at least the top two-thirds of Page 30?

A. Yes.

Q. And I'd like to direct your attention to where it says, "Covered Expenses." You see the different columns and the first one is "Covered Expenses"?

A. Yes.

Q. Okay. Three bold headings down do you see where it says, "hearing Aids"?

A. I do.

Q. And do you see where it says, "100% up to $300 allowance per ear during the period of 3 consecutive years. No dollar limit for cochlear implants"? Do you see that?

A. I do. I do.

Q. All right.

MS. MARISSEAU: Okay. Let's go to Page 80.

Q. [By Ms. Marisseau] All right. Ms. Schmitt, do you see that heading where it says, "Expenses Not Covered"?

A. I --

MS. HAMBURGER: Object as to form, foundation.

THE WITNESS: Sorry.

A. So I continued with the same provider that I had been using, and I don't recall being specifically aware of the rules around that at the time.

Q. [By Ms. Marisseau] Who is the provider that you had been using for a long time?

A. So I had -- I had previously been using, and still use, Ascent Audiology, which has recently changed names to something else. It's like Complete Hearing & Balance or something now, yeah, but I had -- I had been going to them for a while.

Q. Okay. Did you do anything to see if Ascent Audiology in 2016 was in network with Group Health?

A. You know, I hesitate because I don't know the exact time frame. I think at some point I provided them with my insurance card and, again, I can't tell you whether that was 2016 or not.

Q. Did you ever make a call to Group Health prior to buying your hearing aids in 2016 to ask whether or not Ascent Audiology was in network?

A. I did not make a call to ask about whether Ascent Audiology was in network. I, at some point, made

Q. Now, you never submitted any of the charges that we see on Page Schmitt 000238 under Exhibit No. 5, did you?

A. Submitted them to?

Q. Group Health or Kaiser.

A. No, not that I recall.

Q. All right. Why didn't you submit the charges under Jeff's King County Group Health plan?

A. I don't recall. I don't have a clear picture of my thinking at the time. I actually don't believe I was aware that there was a small benefit under that plan.

Q. Did you have access to the Internet in 2016?

A. Sure.

Q. Okay. And you know that the King County plan is online?

MS. HAMBURGER: Object to the form, foundation.

A. I don't know that for a fact, although that's probably true.

Q. [By Ms. Marisseau] Okay. And you were also aware that -- well, have you had the experience of getting what's called a Summary of Benefits at the beginning of a plan year?

MS. HAMBURGER: Object as to form.

around.

Q. [By Ms. Marisseau] Okay.

A. I consulted my provider about different options, as I said before.

Q. So is it your testimony, then, that you didn't submit the claims for your December 2016 hearing aids because the $600 wasn't enough --

MS. HAMBURGER: Object as to form --

Q. [By Ms. Marisseau] -- to cover them?

MS. HAMBURGER: -- misstates.

I'm sorry, Medora, I thought you were done.

Q. [By Ms. Marisseau] It wasn't enough to cover them, I said.

MS. HAMBURGER: Object as to form, misstates the prior testimony; argumentative; asked and answered.

MS. MARISSEAU: Counsel, really? The litany of objections is getting really excessive and completely improper. We're trying to get your witness out of here on time, so maybe you could just keep it to "form" like you're required to.

Q. [By Ms. Marisseau] Ms. Schmitt, I'm going to restate the question.

MS. MARISSEAU: Annamarie, why don't we read it back.

THE COURT REPORTER: Sure.

[The court reporter reads back.]

MS. HAMBURGER: My objection stands from before.

A. So that is not my testimony about the actual reason that I didn't submit the claims in 2016.

Q. [By Ms. Marisseau] Okay.

A. The testimony, which I don't believe I've previously given in this deposition about that, is that I was not aware at the time that there was a benefit in that policy. So that's why I didn't submit at the time.

Your question, I think -- well, I'll stop there.

Q. All right. So the statement, "Schmitt did not submit these claims to Kaiser as it would have been futile" is not correct as to the December 2016 hearing aids, right?

A. I believed at the time that it would have been entirely futile, and I know now that it would have been futile as to the vast majority of the charge.

Q. You believe it would have been futile because you didn't investigate that there was coverage for hearing aids in 2016?

MS. HAMBURGER: Object as to form.

was an agreement.

Q. [By Ms. Marisseau] Ms. Schmitt, are you asserting that the $5,340 charge that you paid for the December 2016 hearing aids is part of the cost that you're seeking to recover in this lawsuit?

A. What I'm thinking in this lawsuit is a recalculation of the -- or a reprocessing of the benefits. I mean, I think those could be appropriately reprocessed given whatever other circumstances, right, the fact that I was eligible for some benefit at the time and didn't claim it because I didn't -- I wasn't aware of it.

Q. I'm going to ask the question again: Are you seeking the $5,340 in charges, are you seeking to have that -- you're calling it reprocessed; it was never processed because you never submitted it, right?

MS. HAMBURGER: Object to the form, argumentative and asked and answered.

Q. [By Ms. Marisseau] Are you saying reprocessed? Is that the phrase that you're using?

A. I said the word "reprocessed," I did, yes.

Q. Okay. But it was never processed because you never submitted any claims, right?

A. It's true that I had never submitted any claim.

C E R T I F I C A T E

STATE OF WASHINGTON)
) ss.
County of Chelan)

I, the undersigned Washington Certified Court Reporter, pursuant to RCW 5.28.010 authorized to administer oaths and affirmations in and for the State of Washington, do hereby certify:

That the foregoing deposition, consisting of Pages 1 through 133, was taken stenographically before me and reduced to a typed format under my direction;

I further certify that, according to CR 30(e), the witness was given the opportunity to examine, read, and sign the deposition after the same was transcribed, unless indicated in the record that the review was waived;

I further certify that I am not a relative or employee of any such attorney or counsel, and that I am not financially interested in the said action or the outcome thereof;

I further certify that each witness before examination was by me duly sworn to testify to the truth, the whole truth, and nothing but the truth;

I further certify that the deposition, as

Exhibit I

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON AT SEATTLE

ANDREA SCHMITT; ELIZABETH MOHUNDRO; and O.L. by and through her parents J.L. and K.L. each on their own behalf, and on behalf of all similarly situated individuals, Plaintiffs, vs. KAISER FOUNDATION HEALTH PLAN OF WASHINGTON; KAISER FOUNDATION HEALTH PLAN OF WASHINGTON OPTIONS, INC.; KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST; and KAISER FOUNDATION HEALTH PLAN, INC., Defendants.	No. 2:17-cv-1611-RSL

DEPOSITION UPON ORAL EXAMINATION OF

J[redacted] L[redacted]

May 11, 2023

Taken at:
Karr Tuttle Campbell
701 Fifth Avenue, Suite 3300
Seattle, Washington 98104

REPORTED BY: KATIE J. NELSON, RPR, CCR/CSR
WA CCR #2971
OR CSR #22-0012
CA CSR #14479

ATTY. HAMBURGER: Object as to form.

THE WITNESS: I'm not familiar with that terminology. We call them behind-the-ear hearing aids.

Q. (By Atty. Marisseau) We'll call it that, behind-the-ear hearing aids.

A. Yeah, in O[redacted]s case, but there are also hearing aids to be inserted into ear canal that could be a possibility in the future.

Q. Are you looking to recover any money in this lawsuit?

A. I would like Kaiser to go back and reprocess the claims and if that happens and some amount of money comes, that's -- it is what it is.

Q. What claims do you look to have Kaiser reprocess?

A. In our case, it's the claim from 2020, but it's -- I believe it should be applied to other people who affected.

Q. So I'm just talking about you, so 2020 --

A. Yes.

Q. Okay.

A. And 2019 as well when the ear molds were not covered.

Q. Are you looking to have Kaiser pay you for out-of-pocket amounts that include deductibles and coinsurance?

ATTY. HAMBURGER: Object as to form;